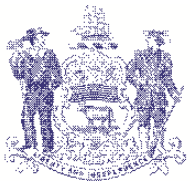
Karen Weldin Stewart, CIR-ML
Commissioner



Delaware Department of Insurance

Issuer QHP Submission Guide

For Coverage Year 2014

Published March 22, 2013

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1. General Information and Background

1.1 *Purpose*

The purpose of this document is to provide guidance to health insurance issuers regarding the certification standards for individual and/or Small Business Health Options Program (SHOP) Qualified Health Plans (QHPs) offered through the federal Health Insurance Exchange. This document is for informational purposes and has no legal force or effect; issuers should refer to applicable Delaware State Code and federal statute, rules, and regulations, as well as state-specific QHP Certification Standards for a more comprehensive and thorough understanding of requirements related to qualified health plans offered in the Exchange. Federal statute and regulations referenced in this document may not be final, and the citations to the same will be updated in future versions of this document when such regulations are made final.

1.2 *Background*

Effective January 1, 2014, the Exchange will offer issuers a state-wide marketplace to make it easier for individuals and small employers and their employees to compare plans and buy health insurance. The Exchange is the only distributional channel through which individuals and small employers will be able to purchase coverage that will be eligible for certain affordability subsidies, including:

- Advanced premium tax credits and/or cost-sharing reductions available to households purchasing coverage in the individual market
- Affordability tax credits available to eligible employers offering coverage in the small group market

In order to comply with certain aspects of the ACA, Delaware has chosen to implement and operate a health benefit exchange through the Federal Facilitated Exchange State Partnership Option (FFE/SPO). To be certified as a QHP on the Delaware Exchange, all issuers and their health plans must meet all pertinent federal and state statutory requirements and standards. Operating in partnership with the US Department of Health and Human Services (HHS), the Delaware Department of Insurance (DOI) will review and recommend certification of QHPs to the federal Department of Health and Human Services (HHS) for ratification of the certification recommendation, allowing for participation in the Exchange. The Affordable Care Act authorizes QHP certification as well as other operational standards for the Exchange in following sections: 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411, and 1412. Federal standards for QHP issuers are codified in 45 CFR 155 and 156. Furthermore, the state of Delaware has approved additional QHP certification standards to be applied to those plans sold within the Delaware Exchange.

The Delaware Exchange will collect data from issuers as part of QHP certification and recertification and monitor compliance with QHP certification standards on an ongoing basis. QHP issuer and plan data will also support additional operational activities, including the calculation of each individual's advance payment of the premium tax credit, the display of plan information on the Exchange web

site, and managing the ongoing relationships between QHP issuers, the DOI, and the Exchange. Much of the information collected for QHP certification purposes will support these ongoing operational activities.

An individual or SHOP health insurance plan certified as a QHP in 2013 will be offered through the Delaware Exchange beginning October 1 to any eligible consumer wanting to purchase coverage, with an effective date of coverage beginning no sooner than January 1, 2014. Health insurance issuers will offer certified QHPs for a term of one year beginning January 1, 2014 and ending December 31, 2014. In addition, Federal regulations allow for the offering of Multi-state Plans (MSPs) that are reviewed and approved by the federal Office of Personnel Management (OPM). The guidance contained in this document does not address these plans. It is unknown at this time if MSPs will be offered on the Delaware Exchange for the 2014 coverage year. Issuers who wish to learn more about MSPs are encouraged to contact OPM or HHS directly.

1.3 *General Exchange Participation Requirements*

To be certified for participation in the Exchange, a QHP must:

- Meet the legal requirements of offering health insurance in Delaware
- Satisfy the certification criteria as established by the State
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR Parts 155 and 156
- Receive a recommendation for certification by the DOI, have the recommendation ratified by HHS, and enter into a Certification Agreement with HHS

In addition, to participate in the Delaware Exchange an issuer must:

- Submit at least one silver plan and one gold plan per 45 CFR 156.200(c)(1), as well as submit at least one bronze plan per Delaware approved standards.
- Provide a child-only option for each metal tier for which the issuer offers a QHP (45 CFR 156.200(c)(2)
- Submit three variations to each silver plan reflecting reduced cost-sharing on the essential health benefits (45 CFR 156.420(a))

1.4 *Timetable*

The following table provides estimated dates for QHP certification process in 2013. Please note that dates are subject to change based on several factors, including many beyond the control of the DOI such as delays in federal guidance, federal timelines, and SERFF enhancements. Issuers will be kept informed of delays through regular communications by the DOI, HHS and NAIC, as well as through stakeholder meetings and other existing communication mechanisms.

Activity	Date *
Delaware EHB Benchmarks and state QHP standards established	November 1, 2012

DOI releases Bulletin to Issuers regarding state standards and inviting them to submit a letter of intent to apply for QHP Certification	December 2012
Issuers register with HIOS and receive HIOS ID	March 2013
Issuer QHP Certification Applications period begins	March 28, 2013
Deadline for Issuers to submit Issuer and Plan Benefit information through SERFF	May 30, 2013
Deadline for Issuers to submit QHP Rate information through SERFF	June 15, 2013
Delaware recommendations for QHP certification provided to HHS** SERFF transmits Issuer data for all recommended QHPs to HIOS	July 31, 2013
Issuers review data on FFE web portal during Plan Preview period and address data errors	1 week late August 2013
HHS notifies State and all Issuers of QHP Certification decision; QHP Agreement signed	Early September 2013
Consumer Open Enrollment Period begins; QHP monitoring activities begin	October 1, 2013
Consumer Open Enrollment period ends	December 31, 2013
Issuer Accreditation deadline for QHPs in the Exchange	September 30, 2014

**** future dates based on existing guidance from CMS and NAIC***
*****Delaware will submit all recommendations for QHP certification concurrently in order to avoid adverse market advantage***

1.5 *Contact Information*

For questions, please contact Janet Brunory, QHP Analyst, Delaware Department of Insurance, as follows:
E-mail: janet.brunory@state.de.us
Phone: 302-674-7374
Mailing Address: 841 Silver Lake Blvd., Dover, DE 19904

The DOI will notify issuers regarding application status, finding, objections and other QHP Review-related topics through SERFF utilizing the Messaging feature.

2. Specifications for QHP Certification

This section outlines the various issuer- and plan-level components that the DOI will require in the QHP submission. *Please note* that prior to completing a "Plans and Benefits Data Template," issuers

must register their HIOS Product IDs via CCIIO's Health Insurance Oversight System (HIOS). Issuers must also have a HIOS Issuer ID issued by HHS for Rate Review.

Each Product ID will come with fifty Plan IDs, each of which is made up of the Standard Component ID and a Variance ID. Issuers must also have a HIOS Issuer ID issued by HHS for Rate Review. QHP data and information will be submitted by issuers to the DOI in SERFF using the methods numbered below. For each QHP certification requirement included in this section, the primary proposed method issuers will use to submit supporting data information is listed. However, this may change prior to the opening of the QHP submission window subject to new guidance and information from CCIIO and the NAIC. As permitted by the ACA, issuer and plan data and information required for initial QHP certification and ongoing monitoring will be forwarded by the DOI securely and directly to HHS through SERFF.

At the time of publication this guide, the CCIIO MS Excel Data Templates referenced below are in proposed form and can be found at the following location under "Documentation – Business": http://www.serff.com/hix.htm

- Built-in Onscreen SERFF Data Entry Fields - E.g., Plan Binder Name, Plan Year, Market Type
- CCIIO Standard MS Excel Data Templates (as attachments) - E.g., Administrative Data, Plan and Benefit Data, Rate Data, Formulary Data
- Supporting Documents (as attachments) - E.g., Certification of Compliance, Actuarial Memorandum, and Certificate of Readability
- Attestations (as a PDF attachment) - E.g., "Issuer will adhere to all requirements contained in 45 CFR 156, applicable law and applicable guidance"

2.1 *Issuer Administrative Information*

This information will be issuer-specific and will only need to be submitted once, per issuer, for all related initial QHP application submissions. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

Not applicable

DOI/HHS Approach to Certification

The QHP filing process requires submission of certain general administrative data that will be utilized for operational purposes. This basic information is required to identify issuers and the Exchange markets they intend to serve, and to facilitate communications with and payment to issuers. The data elements may include issuer contact information and banking information. *(See 508 Appendices A1 and A4 of Paperwork Reduction Act package, CMS Form Number CMS-10433, for additional information.)*

Please see the "Administrative Data Template" for detail on the data elements to be collected.

Primary data submission method(s): CCIIO MS Excel Data Templates

2.2 *Licensure, Solvency, and Standing*

This information will be issuer-specific and will only need to be submitted once, per issuer, for all related initial QHP application submissions. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

An issuer must be licensed, meet State solvency requirements, and have unrestricted authority to write its authorized lines of business in the State of Delaware in order to be considered "in good standing" and to offer a QHP through the Exchange. Good standing means that the issuer has no outstanding sanctions imposed by the DOI (45 CFR 156.200(b)(4)).

DOI/HHS Approach to Certification

The DOI's Bureau of Examination, Rehabilitation & Guaranty (BERG) will review and confirm issuers submitting QHPs meet these standards, leveraging existing information and data sources to review the status of an issuer's license, solvency, and standing. Consequently, issuers licensed in Delaware will not be required to submit supporting documentation for this certification standard initially unless concerns are identified and additional review is required. Issuers that are not currently licensed will be required to complete the Delaware licensing process, which is handled by the DOI's BERG unit. Delaware is a NAIC Uniform Certificate of Authority Application (UCAA) participant state; therefore, Delaware accepts the UCAA Primary and Expansion Applications. To obtain a license in Delaware, insurers and stand-alone dental plans must follow the procedures outlined in the UCAA Primary and Expansion Applications.

Primary data submission method(s): Attestations

2.3 *Benefit Standards and Product Offerings*

This information will be QHP-specific and will need to be included for each submitted QHP in the issuer's application. With the exception of Section 2.3.5, this section also applies to stand-alone dental plans.

Plan-specific information not captured in other sections will be collected, including data elements such as Plan ID, whether or not the plan is offered in the individual or SHOP Exchange market and/or off of the Exchange, and plan effective date.

Additionally, issuers must submit benefits information for each QHP. QHP issuers must ensure that each QHP complies with the benefit design standards (specified in the ACA and subsequent rules (45 CFR §156.200(3)), including:

- Federally approved State-specific essential health benefits (EHB)
- Federally approved State-specific QHP standards, *as applicable*
- Cost-sharing limits
- Actuarial value (AV) requirements
- Non-discriminatory benefit design
- Mental health parity

QHP offerings must also reflect meaningful differences amongst products to ensure that a manageable number of distinct plan options are offered.

Sections 2.3.1 – 2.3.6 provide additional requirements related to Benefit Design standards.

2.3.1 Essential Health Benefits

Statutory/Regulatory Standard

All small group and individual health benefit plans sold inside and outside of the Exchange must cover a core set of "essential health benefits" as defined by HHS. Coverage must be substantially equal to the coverage offered by a benchmark plan, and the plan must cover at least the greater of one drug in every USP category and class or the same number of drugs in each category and class as benchmark plan (45 CFR 156.110, 156.115, 156.1207).

Delaware has selected the state's Small Group Blue Cross/Blue Shield (BCBS) EPO as its Essential Health Benefit benchmark. At the time of approval, the BCBS EPO plan had the largest enrollment in the Small Group plan currently available in Delaware. The state has also selected to include the following supplements for pediatric dental and vision and habilitative services to augment the BCBS EPO plan.

Pediatric Dental

- Delaware has selected the state's Medicaid/CHIP Dental Plan as a supplement to its EHB benchmark plan to cover pediatric dental benefits.

Pediatric Vision

- Delaware has selected the Federal Employee Program Blue Vision Plan (FED Blue Vision) as a supplement to its EHB benchmark plan to cover pediatric vision benefits.

Habilitative Services

- As provided under existing federal guidance, Delaware will require that coverage for habilitative services be on parity with those for rehabilitative services as outlined in the state's Essential Health Benefit benchmark.

Delaware requests that issuers include information indicating how frequently the issuer updates its formularies, as well as information on the issuer's process for providing the state with advance notification of such updates.

DOI/HHS Approach to Certification

In its review, the DOI will confirm the following:

- Issuer offers coverage that is substantially equal to the benchmark plan
- Issuer has demonstrated actuarial equivalence of substituted benefits if the issuer is substituting benefits
- Issuer provides required number of drugs per category and class

EHB substitutions will require an actuarial certification to support that the substitutions are compliant and actuarially equivalent substitutions (45 CFR 156.115(b)(2)). HHS is working on an actuarial tool to determine actuarially-equivalent EHB substitutions, and further HHS guidance is expected. Data will be collected on health benefits, including covered drugs, and issuers will submit Summary of Benefits and Coverage (SBC) Scenario results. Please see the "Plans and Benefits Data Template" and "Prescription Drug Data Template" for additional detail on the data elements to be collected.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations, Supporting Documents

2.3.2 Annual Cost-Sharing Limitations

Statutory/Regulatory Standard

All small group and individual health benefit plans sold inside and outside of the Exchange must meet the following annual cost-sharing limits in 2014 (45 CFR 156.130):

- Out-of-Pocket Limits: The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

- Deductibles: Employer-sponsored plans may not have a deductible in excess of $2,000 for a plan covering a single individual or $4,000 for other coverage. The deductible limit may be increased by the maximum amount of reimbursement reasonably available to an employee under a flexible spending arrangement.

Beginning in 2015, all of the cost-sharing limits will be indexed to per-capita growth in premiums in the United States as determined by HHS.

While the annual limitation on cost-sharing for a QHP must be consistent with 45 CFR 156.130, proposed rule 45 CFR 156.150 indicates the annual limitation on cost-sharing for a stand-alone dental plan would be considered separately. The plan must demonstrate the annual limitation on cost-sharing for the stand-alone dental plan is "reasonable" for coverage of the pediatric dental EHB.

DOI/HHS Approach to Certification

The DOI will review plan data for compliance with ACA cost-sharing limitations. Benefit cost-sharing (e.g., quantitative limits, co-payments, and co-insurance by benefit), plan cost-sharing (e.g., in–network and out–of–network deductibles), and pharmacy benefit cost-sharing data elements will be collected; please see the "Plans and Benefits Data Template" and "Prescription Drug Data Template" for additional detail on required data elements.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations

2.3.3 Actuarial Value

Statutory/Regulatory Standard

Except for the impact of cost-sharing reduction subsidies and a *de minimis* variation of +/- 2 percentage points, each plan in a metal tier must meet the specified AV requirements based on the cost-sharing features of the plan (45 CFR 156.140):

- Bronze plan – AV of 60 percent
- Silver plan – AV of 70 percent
- Gold plan – AV of 80 percent
- Platinum plan – AV of 90 percent
- Catastrophic plan – N/A8 *(Please see ACA §1302(e) for details on catastrophic plans and individuals eligible for them.)*

Additionally, Delaware requires that issuers are required to offer *at least one* QHP at the Bronze level, as well as the Silver and Gold as required by the federal standard

With exceptions for unique plan designs, issuers must use an actuarial value calculator, provided by HHS for use within the SERFF application, to produce computations of a QHP's metallic level based upon benefit design features. The AV calculator *may* also be used by issuers informally for plan design. For unique plan designs for which the calculator does not provide an accurate summary of plan generosity, an actuarial certification is required from the issuer indicating compliance with one of the calculation methods described in 45 CFR 156.135(b)(2).

Per proposed rule 45 CFR 156.150, standalone dental plans may not use the HHS-developed AV calculator. Instead, any stand-alone dental plan certified to meet a 75 percent AV, with a *de minimis* range of +/- 2 percentage points, be considered a ''low'' plan and anything with an AV of 85 percent, with a *de minimis* range of +/- 2 percentage points, be considered a ''high'' plan. The ''high/low'' actuarial value standard would apply to the pediatric dental EHB only in a stand-alone dental plan; when the pediatric dental EHB is included in a health plan, the AV calculator would apply to the pediatric dental EHB.

In addition, Delaware requires that all stand-alone dental plans must be compliant with Delaware code, Title 18, Chapter 38: Dental Plan Organization Act.

DOI/HHS Approach to Certification

The DOI will review and confirm that the AV for each QHP meets specified levels and review unique plan designs and the accompanying actuarial certification, if applicable.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations, Supporting Documents

2.3.4 Non-Discrimination

Statutory/Regulatory Standard

An issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (45 CFR 156.125). In addition, QHPs must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR 156.200(e)) and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs (45 CFR 156.225(b)).

DOI/HHS Approach to Certification

Issuers will be required to attest to non-discrimination on these factors for both federal and state standards. In addition, the DOI may conduct outlier tests to identify potentially discriminatory benefit designs when a Federal analytic tool becomes available.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations

2.3.5 Mental Health Parity and Addiction Equity Act

Statutory/Regulatory Standard

All individual and small group plans sold inside and outside of the Exchange are required to comply with the Mental Health Parity and Addiction Equity Act (ACA § 1311(j)).

Additionally, Issuers are reminded that the state requires plans offered in the Individual Exchange market to comply with Delaware Insurance code 18Del.C §3343, and plans offered in the small group market to comply with 18 Del.C §3578.

DOI/HHS Approach to Certification

The DOI will review benefits and cost-sharing for compliance with this standard, including ensuring that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations

2.3.6 Continuity of Care

Delaware QHP Certification Standards

Delaware specific certification standards regarding Continuity of Care include:

- A QHP Issuer must have a transition plan for continuity of care for those individuals who become eligible or lose eligibility for public health programs. The Continuity of Care Transition Plan must include a transition period for prescriptions, including how the plan specifically addresses mental health pharmacy. In such instances, the new plan is responsible for executing the Transition plan. Transition plans are not applicable for individuals who **voluntarily** disenroll in a QHP, do not enroll in another QHP, but are still not eligible for Medicaid/CHIP.
- For treatment of a medical condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, the QHP issuer/plan must cover the service for a lesser of: a period of 90 days or until the treating provider releases the patient from care.
- A continuity/transition period of at least 60 days must be provided for medications prescribed by a provider. If the QHP uses a tiered formulary, the prescribed medication must be covered at tier comparable to the plan from which the individual was transitioned.
- For mental health diagnosis, a continuity/transition period of at least 90 days must be provided by the QHP for medications prescribed by the treating provider for the treatment of the specific mental health diagnosis. The prescribed medication must be covered at a tier comparable to the plan from which the individual transitioned.
- The QHP issuer must provide for reimbursement of a licensed nurse midwife subject to 16 Del.C§122, and as outlined in 18 Del.C. §3336 and§3553.
- The QHP issuer must permit the designation of an obstetrician-gynecologist as the enrollee's primary care physician subject to the provisions of Delaware Insurance code 18Del.C.§§3342 and3556
- The QHP issuer must make appropriate provider directories available to individuals with limited English proficiency and/or disabilities.
- Withdrawal from Exchange: The QHP Issuer must comply with the following state regulations in the event that it withdraws either itself or a plan(s) from the Exchange:
    - Issuers withdrawing plans for Individuals must comply with 18 Del.C. §§3608(a)(3)a, and 3608(a)(4), which states:

(a) An individual health benefit plan shall be renewable with respect to an enrollee or dependents at the option of the enrollee, except in the following cases:

(3): A decision by the individual carrier to discontinue offering a particular type of health benefit plan in the state's individual insurance market. A type of health benefit plan may be discontinued by the carrier in the individual market only if the carrier:

a. Provides notice of the decision not to renew coverage to all affected individuals and to the Commissioner in each state in which an affected insured individual is known to reside at least 90 days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the Commissioner under this subparagraph shall be provided at least 3 working days prior to the notice to the affected individuals;

(4) The carrier elects to discontinue offering and to nonrenew all its individual health benefit plans delivered or issued for delivery in the state. In that case, the carrier shall provide notice of its decision not to renew coverage to all enrollees and to the Commissioner in each state in which an enrollee is known to reside at least 180 days prior to the

nonrenewal of the health benefit plan by the carrier. Notice to the Commissioner under this paragraph shall be provided at least 3 working days prior to the notice of the enrollees;

- Issuers withdrawing Small Group plans must comply with 18 Del.C. §§7206 (a)(5),7206(a)(6) and 7206(b), Renewability of coverage, which states:

  (a) A health benefit plan subject to this chapter shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases

  5) Repeated misuse of a provider network provision;

  (6) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this State. In such a case the carrier shall:

  a. Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and

  b. Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subparagraph shall be provided at least 3 working days prior to the notice to the affected small employers; (b) A small employer carrier that elects not to renew a health benefit plan under subsection (a)(6) of this section shall be prohibited from writing new business in the small employer market in this State for a period of 5 years from the date of notice to the Commissioner.

Issuers must submit a withdrawal and transition plan to the Department of Insurance for review/approval.

DOI/HHS Approach to Certification

The DOI will review issuer transition plans for compliance with continuity of care standards, as well as issuer attestations.

Primary data submission method(s): Attestations, Supporting Documents

2.4 *Rating Factors and Rate Increases*

This information will be QHP-specific and will need to be included for each submitted QHP in the issuer's application. At this time, HHS has not further defined specific information related to dental plan rating factors.

Statutory/Regulatory Standard

Issuers offering non-grandfathered health insurance coverage in the individual and small group markets starting in 2014, and the large group market if such coverage is available through an Exchange starting in 2017, must limit variation in plan premiums to age, tobacco use (subject to wellness program requirements in the small group market), family size, and geography (45 CFR 147.102; 45 CFR 156.255). The Federal rule prohibits the use of other rating factors such as health status, medical history, gender, and industry of employment to set premium rates.

Proposed Federal rules related to rate-setting are listed below:

Standards are contained in proposed Federal rules expected to be final in early 2013.

- *Tobacco Use*. Rates based on tobacco use may vary by up to 1.5:1.
- *Family Composition*. Issuers must add up the premium rate of each family member to arrive at a family rate. However, the rates of no more than the three oldest family members who are under age 21 would be used in computing the family premium.
- *Geography*. A state is to have a maximum of seven rating areas. The rating area factor is required to be actuarially justified for each area.
- *Age*. Issuers must use a uniform age rating curve that specifies the distribution of relative rates across all age bands and is applicable to the entire market. The federal government's proposed age curve anchors the premium amount to age 21, and is expressed as a ratio, for all ages between ages 0 and 64, inclusive, subject to the following:
    - Children: single age band covering children 0 to 20 years of age, where all premium rates are the same
    - Adults: one-year age bands starting at age 21 and ending at age 63
    - Older adults: a single age band covering individuals 64 years of age and older, where all premium rates are the same
    - Rates for adults age 21 and older may vary within a ratio of 3:1

In addition, Delaware has established, as part of its QHP Standards, *a single rating area* to be applied to the entire state.

Furthermore, Issuers must:

- Set rates for an entire benefit year, or for the SHOP, plan year;
- Charge the same premium rate without regard to whether the plan is offered through the FFE or directly from the issuer through an agent and is sold inside or outside of the Exchange;
- Submit rate information to the Exchange at least annually;
- Submit a justification for a rate increase prior to the implementation of the increase; and
- Prominently post the justification on its Web site (45 CFR 156.210).

Rate increases for QHPs are subject to the reporting and review requirements in 45 CFR 154.215 related to the submission of a Rate Filing Justification, inclusive of:

- An HHS standardized Unified Rate Review data template
- A Consumer Narrative Justification (for increases subject to the review threshold)
- An actuarial memorandum providing the reasoning and assumptions that support the data submitted in the data template and an actuarial attestation

<u>DOI/HHS Approach to Certification</u>

The DOI will review rates for compliance with rating standards, as well as issuer attestations. For rate increases, a review of the Rate Filing Justification, including Actuarial Memorandum, will be performed. *(Please see the "Rates," "Rate Review," and "Business Rules" Data Templates for detail on the data elements to be collected.)*

The state may conduct an outlier test on QHP rates to identify rates that are relatively high and low compared to other QHP rates in the same rating area.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestation, Supporting Documents

2.5 *Accreditation Standards*

This information will be issuer-specific and will only need to be submitted once, per issuer, for all related initial QHP application submissions. This section does not apply to stand-alone dental plans.

Statutory/Regulatory Standard

During an issuer's initial year of QHP certification (e.g., in 2013 for the 2014 coverage year), a QHP issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in Delaware granted by a HHS recognized accrediting entity or must have scheduled, or plan to schedule, a review of QHP policies and procedures with a recognized accrediting entity (45 CFR 155.1045).

Per 45 CFR 155.1045, prior to a QHP issuer's second and third year of QHP certification (e.g. in 2014 for the 2015 coverage year), a QHP issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products or must have commercial or Medicaid plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is offering Exchange coverage and the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP.

Delaware will follow the proposed federal standards for accreditation, including requiring that those QHP issuers without existing accreditation must schedule the accreditation within the first year of participation in the exchange, and to be accredited on QHP policies and procedures by the end of the second year of certification. The state *will also require in the third year of operation*, that all QHP issuers must be accredited on the QHP product type. While all Issuers must comply with existing state and federal codes and regulations, Issuers of stand-alone dental plans are exempt from the state's Accreditation standard until such time as accreditation standards, entities and processes are available through federal guidance.

Accreditation must be on the basis of local performance in the following categories (45 CFR 156.275):

- Clinical quality measures, such as the HEDIS
- Patient experience ratings on a standardized CAHPS survey
- Consumer access
- Utilization management
- Quality assurance
- Provider credentialing
- Complaints and appeals
- Network adequacy and access
- Patient information programs

DOI/HHS Approach to Certification

In 2013, data verifying accreditation status is expected to be received directly in SERFF from the NCQA and URAC. Issuers meeting accreditation standards in the initial year must authorize the

release of accreditation survey data to the DOI and Exchange. An accreditation data file will be received by the NAIC from accrediting entities, loaded into SERFF, and made available for display as part of the plan submission (data will also be sent to HHS). In addition, issuers, regardless of accreditation status, must provide attestations including acknowledgment that, prior to 2016, CAHPS® data may be used on the Exchange Internet website and the website may display that a QHP issuer is accredited if that issuer is accredited on its commercial, Medicaid or Exchange product lines.

Primary data submission method(s): Built-in SERFF Fields, Attestations

2.6 *Network Adequacy and Provider Data*

This information may be issuer or QHP-specific. If the provider network within the service area is consistent across all products and plans sold by the issuer, the issuer may provide required information and attestations only once. If there is any variation in the provider networks across QHPs, information will need to be provided for each product and/or plan. With the exception of 2.6.3, Mental Health and Substance Abuse providers, this section also applies to stand-alone dental plans.

2.6.1 General

Statutory/Regulatory Standard

Per 45 CFR 155.1050, the Exchange must ensure that enrollees of QHPs have a sufficient choice of providers. A QHP's provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay (45 CFR 156.230(a)(2)).

Issuers and QHPs must meet the following certification standards for Network Adequacy as specified in CFR 156.230, which state that a *QHP issuer must ensure that the provider network of each of its QHPs is available to all enrollees and meets the following standards-*

- Includes essential community providers in accordance with§156.235;
- Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,
- Is consistent with the network adequacy provisions of section 2702© of the PHS Act,
- (b) Access to provider directory. A QHP issuer must make its provider director for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

Issuers must have sufficient number of and geographic distribution of essential community providers where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service area.

Additional Delaware specific certification standards regarding Network Adequacy include:

- QHP network arrangement must make available to every member a Primary Care Provider (PCP) whose office is located within 20 miles or no more than 30 minutes driving time from the member's place of residence. If available, please provide justification or demographic information to verify compliance with requirement that every member can access a Primary Care Provider (PCP) whose office is located within 20 miles or no more than 30 minutes driving time from the member's place of residence.
- Each QHP issuer that has a network arrangement must meet and require its providers to meet state standards for timely access to care and services as outlined in the table, titled **Appointment Standards,** found on page 27 of 84 in the Delaware Medicaid and Managed Care Quality Strategy 2010 document relating to General, Specialty, Maternity and Behavioral Health Services. Issuers must have providers in the plan network that cover services in all ten essential health benefits or must submit justification for access to care at in-network rates and without balanced billing.
- Issuers must establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance and take corrective action if there is a failure to comply with Network Standards.
- QHP networks must be comprised of hospitals, physicians, behavioral health providers, and other specialists in sufficient number to make available all covered services in a timely manner.
- Each primary care network must have at least one (1) full time equivalent Primary Care Provider for every 2,000 patients. The QHP issuer must receive approval from the Insurance Commissioner for capacity changes that exceed 2500 patients
- Issuers of stand-alone dental plans are exempt from the state's network adequacy standards for medical and mental health providers. However, Stand-alone dental plans must comply with SSA 1902(a)(30)(A), and assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

<u>DOI/HHS Approach to Certification</u>

To fulfill the network adequacy requirement, an issuer must be accredited with respect to network adequacy by an HHS-recognized accrediting entity and attest to complying with the following standards to demonstrate it has an adequate range of providers for the intended service areas:

- Issuer will maintain a provider network that is sufficient in number and types of providers to assure that all services are accessible without unreasonable delay, as specified in 45 CFR 156.230(a)(2)
- Issuer's network meets applicable Delaware network adequacy requirements as defined above.
- Issuer's network reflects executed contracts for the year in which the issuer is applying.

If the issuer is not accredited or is accredited but cannot respond affirmatively to each of the attestations, a network access plan must be submitted. In general, the access plan may include, but is not limited to, the following types of information based on the NAIC Model Act #47 requirements:

- Standards for network composition
- Referral policy
- Needs of special populations

- Health needs assessment
- Communication with members
- Coordination activities
- Continuity of care

The DOI will monitor network adequacy, for example, via complaint tracking and/or gathering network data from any QHP issuer at any time to determine whether the QHP's network(s) continues to meet federal and state certification requirements.

Primary data submission method(s): Attestations, Supporting Documents

2.6.2 Essential Community Providers

Statutory/Regulatory Standard

Issuers must ensure that the provider network for a QHP has a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area (45 CFR 156.235).

ECPs are defined in section 340B(a)(4)of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV)of the Social Security Act. ECPs are provider organizations that by legal obligation, organizational mission, or geographic location serve a patient population that has been at risk for inadequate access to care.

Additionally, the Delaware Exchange requires that each health plan, as a condition of participation in the Exchange, shall (1) offer to each Federally Qualified Health Center (as defined in Section 1905(I)(2)(B) of the Social Security Act (42 USC 1369d(I)(2)(B)) providing services in geographic areas served by the plan, the opportunity to contract with such plan to provide to the plan's enrollees all ambulatory services that are covered by the plan that the center offers to provide and (2) reimburse such centers for such services as provided in Section 1302(g) of the Patient Protection and Affordable Care Act (Publ. L.111-148) as added by Section 10104(b)(2) of such Act.

DOI/HHS Approach to Certification

In this section, issuers must denote the ECP's with which they have contracts for each network in which they plan to provide coverage.

Based on an HHS-developed ECP list, the DOI will verify one of the following:

- Issuer achieves at least 20% ECP participation in network in the service area and agree to offer contracts to at least one ECP of each type available by county,
- Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its QHP submission
- Issuer complies with additional Delaware standards regarding Federally Qualified Health Centers as defined above
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.

Justifications submitted by issuers that fail to achieve any standard will undergo stricter review by the DOI.

Issuers that provide a majority of covered services through employed physicians or a single contracted medical group must comply with the alternate standard established by the Exchange (45 CFR 156.235(b)), as follows:

- Issuer has at least the same number of providers located in designated low-income areas
- Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its QHP submission
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission

Both HHS and the state anticipate that it will be difficult for issuers that do not meet the state and federal regulatory standards and state-specific QHP standards. Failure to achieve compliance with these standards will be a basis for not certifying a plan as a QHP. To assist issuers in identifying these providers, CMS is publishing a non-exhaustive list of available ECPs based on data maintained by CMS and other federal agencies, and will include identifying and contact information for each provider.

Data elements requested may include Essential Community Provider name, an in-network indicator, or alternative documentation for non-standard essential community providers. Issuers will indicate which ECPs are included in their provider network(s) by populating a template as part of the QHP application. *(Please see the "Essential Community Providers Data Template" for more detail on the data elements to be collected.)* Issuers will be permitted to write in ECPs not on the CMS-developed list for consideration as part of the DOI's review.

Primary data submission method(s): Attestation, CCIIO MS Excel Data Templates, Supporting Documents

2.6.3 Mental Health and Substance Abuse Services

Statutory/Regulatory Standard

Issuers must ensure that the provider network for the QHP has a sufficient number and type of providers that specialize in mental health and substance abuse services to assure that mental health and substance abuse services will be accessible without unreasonable delay (45 CFR 156.230(a)(2)).

Additionally, Issuers are reminded that the state requires plans offered in the Individual Exchange market to comply with Delaware Insurance code 18Del.C §3343, and plans offered in the small group market to comply with 18 Del.C §3578.

DOI/HHS Approach to Certification

Issuers must establish a standard to assure that the QHP network complies with the Federal standard. A copy of this standard must be included in this application, and the issuer must certify that the provider network for this QHP meets this standard.

Primary data submission method(s): Attestation, Supporting Documents

2.6.4 Service Area

This information will be QHP-specific and will need to be included for each QHP in the issuer's submission. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

The entire geographic area of the State is in the service area of an Exchange, or multiple Exchanges consistent with §155.140(b) The State of Delaware will require Qualified health plan(s) offered by an issuer to be available in all three counties of Delaware.

DOI/HHS Approach to Certification

Data elements such as service area ID and name will be collected from issuers using the CCIIO standard data template and reviewed by the DOI for compliance with the State standard. Please note that the standard SERFF template used includes a field to indicate whether or not the service area is a partial county; this does not apply in Delaware. (*Please see the "Service Area Data Template" for additional detail on the data elements to be collected.)*

Primary data submission method(s): CCIIO MS Excel Data Template, Attestation

2.6.5 Provider Directory

Statutory/Regulatory Standard

A QHP issuer must make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request (45 CFR 156.230 (b)).

DOI/HHS Approach to Certification

For benefit year 2014, issuers will be asked to provide their network names, IDs, and active URL in a Network Template *(included as part of the "Plans and Benefits Data Templates")*.

Primary data submission method(s): CCIIO MS Excel Data Templates

2.7 *Marketing, Applications, and Notices*

This information may be issuer-specific or QHP-specific. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

Issuers must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in their QHP (45 CFR 156.225). In addition, all QHP enrollee applications and notices must comply with Federal standards in 45 CFR 155.230 and 156.250, including being provided in plain language and language that is accessible to people with Limited English Proficiency and disabilities.

Issuers must also comply with Delaware State laws and regulations regarding marketing by health insurance issuers, including Delaware Insurance Code Title 18§23 Unfair Methods of Competition and Unfair or Deceptive Acts and the requirements defined in 18 Del Admin Code§ 1302 Accident and Sickness Insurance Advertisements.

DOI/HHS Approach to Certification

Issuers will be asked to attest to compliance with the ACA requirements related to non-discrimination in marketing practices. Issuers must also submit a copy of all marketing materials, application, and notices for DOI review and approval.

Primary data submission method(s): Attestation; Supporting Documents

2.8 *Quality Standards*

This information may be issuer-specific or QHP-specific. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

By 2016, HHS will develop a rating system that will rate QHPs offered through an Exchange in each benefits level on the basis of the relative quality and price (ACA § 1311(c)(3)) and an enrollee satisfaction survey system (ACA § 1311(c)(4)). In addition, issuers must implement a Quality Improvement Strategy (QIS) that complies with the description in ACA § 1311(g)(1), i.e., uses provider reimbursement or other incentives to improve health outcomes, prevent hospital readmissions, improve patient safety, and implement wellness programs.

Additionally, per federal regulation 45 CFR, §156.20, Issuers must:

- Implement and report on a quality improvement strategy or strategies consistent with standards of section 1311(g) of the Affordable Care Act, disclose and report information on healthcare quality and outcomes described in sections 1311(C) (1) (H) and (l) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable care Act; Strategies in ACA Section 1311(g)
- A payment structure that provides increased reimbursement or other incentives for improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;
- The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional;
- The implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;
- The implementation of wellness and health promotion activities;

- The implementation of wellness and health promotion activities; and
- The implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

HHS intends to propose in future rulemaking that quality reporting requirements related to all QHP issuers (other than accreditation reporting) become a condition of QHP certification, beginning in 2016, based on the 2015 coverage year; such regulatory proposals would be part of the implementation of Affordable Care Act § 1311(c)(1)(E), 1311(c)(3), 1311(c)(4), 1311(g), and 1311(h).

Delaware will also apply the following state-specific QHP Certification Standards with regard to Quality Improvement Strategy.

- Issuers will be required to participate in state quality improvement workgroups intended to standardize QHP quality improvement strategies, activities, metrics and operations, including payment structures to improve health outcomes, medical home models and technology and data analytics to support coordination and improved quality and outcomes.
- Issuers, with the exception of those who provide stand-alone dental plans only, will be required to participate in and utilize the Delaware Health Information Network (DHIN) data use services and claims data submission services, at prevailing fee structure, to support care coordination and a comprehensive health data set as a component of state quality improvement strategy.

DOI/HHS Approach to Certification

Issuers will be required attest to compliance with various Federal and State quality requirements (see Section 3 for details). Future quality and quality improvement standards will be developed for 2016.

Primary data submission method(s): Attestation, Supporting Documentation

2.9 *Meaningful Difference to Support Informed Consumer Choice*

Delaware intends to ensure that consumers can make an informed selection among plan choices that the consumer can readily differentiate and compare, and that one issuer does not impede competition by submitting a number of very similar QHPs that monopolize virtual "shelf space."

To balance these priorities, DOI will conduct a benefit package review for all QHPs offered by an issuer. The goal of this review is to identify QHPs that are not meaningfully different from other QHPs offered by the same issuer and with the same plan characteristics. As in other areas, DOI will use this review to target QHPs for additional review and discussion with the issuer.

2.10 *SHOP-specific Requirements*

This information is QHP-specific. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

SHOP QHPs will be required to comply with SHOP-specific criteria as outlined in 45 CFR §156.285 of the final federal rule.

SHOP QHPs will also be required to comply with the following federal and state regulations and standards:

- Federal regulation 45 CFR §155.725 describing Employer-defined contribution approach
- Delaware Insurance code 18Del.C. §7205(4) regarding restrictions relating to premium rates
- Delaware Insurance code 13Del.C. §2 regarding dependent coverage
- Delaware Insurance code 18 Del.C. §3513 regarding grace period for premium payment
- Delaware Insurance code 18 Del.C. §7206(a)(6)(a and b) regarding noticing requirements related to non-renewal of all its health benefit plans

The DOI also reminds Issuers and brokers/producers that, within the Individual Exchange and FF-SHOP, Issuers are required to pay the same commissions offered in the state outside the exchange for similar product offerings.

DOI/HHS Approach to Certification

Reviews of SHOP plans will be conducted through the same process, timelines and criteria as for Individual plans with the exception that SHOP plans will also be reviewed for compliance with the standards mentioned above.

Primary data submission method(s): Attestation, Supporting Documentation

2.11 *Segregation of Funds for Abortion Services*

This information is QHP-specific. This section does not apply to stand-alone dental plans.

Statutory/Regulatory Standard

In the case of issuers that cover abortions for which federal funding is prohibited, the ACA bars the use of federal funds "attributable" to either the advance refundable tax credit or cost-sharing reduction under the Act for those abortions. The ACA requires issuers to create allocation accounts that separate the portion of premiums/tax credits/cost-sharing subsidies for covered services *other* than non-excepted abortions from the premium amount equal to the actuarial value of the coverage of abortion services. Issuers must exclusively use funds from these separate accounts to pay for the services for which the funds were allocated (e.g., funds for services other than non-excepted abortions cannot be used to pay for non-excepted abortions).

Additionally, the ACA requires issuers to provide a notice to enrollees of abortion coverage as part of the summary of benefits and coverage explanation at the time of enrollment; specifies that notices

provided to enrollees, advertisements about qualified plans, information provided by Exchanges, and any other information specified by the Secretary, must provide information with respect to the total amount of the combined premium/tax credit/cost sharing subsidy payments for services covered by the plan and in connection with abortions for which federal funding is prohibited; and prohibits qualified health plans from discriminating against any health care provider or any health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortion.

Issuers offering coverage for non-excepted abortion services must submit a segregation plan that details its process and methodology for meeting the requirements of Section 1303(b)(2)(C), (D), and (E) of the ACA. The segregation plan must describe the health plan's financial accounting systems, including appropriate accounting documentation and internal controls17, which would ensure the segregation of funds required by the ACA. The plan should address items including the following:

- The financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of non-excepted abortion services from those received for coverage of all other services, which may be supported by Federal premium tax credits and cost-sharing reduction payments
- The financial accounting systems, including accounting documentation and internal controls that would ensure that all expenditures for non-excepted abortion services are reimbursed from the appropriate account
- An explanation of how the health plan's systems, accounting documentation, and controls meet the requirements for segregation accounts under the law

DOI/HHS Approach to Certification

Issuers will be asked to annually attest that they will comply with Federal requirements related to segregation of funds for abortion services, as well as provide a segregation plan. The DOI will perform periodic financial audits of each QHP to assure compliance with Section 1303 of the ACA.

Primary data submission method(s): Attestation, Supporting Documents

2.12 *Past Complaints/Compliance*

This review may be issuer-specific or QHP-specific. This section also applies to stand-alone dental plans.

Statutory/Regulatory Standard

The Exchange may certify a health plan as a QHP if it determines it is in the interest of qualified individuals and qualified employers in the State to do so (155.1000 (c)(2)).

DOI/HHS Approach to Certification

As part of the "interest" standard, the DOI may perform an analysis of past compliance and complaints for existing insurers. Existing data sources will be used for this analysis, therefore issuers are not required to complete or upload any specific data for this standard.

Primary data submission method(s): None

2.13 *Summary of Required Attachments*

Documents listed in this section may or may not apply to stand-alone dental plans, as indicated in previous sections.

The following required documentation should be submitted as attachments in SERFF.

A. Actuarial certification for EHB substitutions (*if applicable*)
B. Actuarial certification for unique plan designs using approved calculation methodology to determine plan actuarial value as an alternative to the AV calculator (*if applicable*)
C. Actuarial memorandum and rate abstract for the review of rates
D. Continuity of Care Plan(s)
E. Transition Plan for Prescriptions (including how the plan specifically addresses mental health pharmacy)
F. Decertification/Voluntary Withdrawal Transition Plan(s)
G. Network access plan for issuers not accredited by an HHS-approved accrediting entity on network adequacy (if applicable)
H. Network adequacy standard regarding mental health and substance abuse providers
I. Time/distance for network providers for each QHP
J. Essential Community Provider list
K. Narrative justification for not meeting ECP standards
L. Marketing materials, enrollee applications and notices, and associated Certificate(s) of Readability
M. Segregation plan for funds used for abortion services
N. Compliance plan, in or ready for implementation, consisting of:
    a. Written policies, procedures, and standards of conduct
    b. Designated Compliance Officer and a compliance committee
    c. Compliance training and education
    d. Effective lines of communication
    e. Well-publicized disciplinary standards
    f. A system for routine monitoring and the identification of compliance risks
    g. Procedures and a system for prompt responses to compliance issues
    J. Organization chart

3. Issuer Attestations

Documents including all attestations will be available for download by issuers in SERFF. Issuers will review, complete, provide an electronic signature, and upload back into SERFF.

3.1 *HHS Requirements*

The following attestations were developed by HHS and are therefore subject to change by them. CCIIO and the NAIC have indicated issuers will be able to download a PDF document with the attestations in SERFF, provide an electronic signature, and upload back into SERFF for submission to the State and HHS.

3.1.1 General

1. As a QHP issuer, applicant will adhere to all requirements contained in 45 CFR 156, applicable law, and applicable guidance.
2. Applicant attests that it has a compliance plan that adheres to all applicable laws, regulations, and guidance and that the compliance plan is ready for implementation.
3. If yes, upload a copy of the applicant's compliance plan.
4. Applicant agrees to adhere to the compliance plan provided.
5. Applicant attests that it will inform HHS of any significant changes to the organizational chart submitted that occur after the submission of this application.
6. If yes, upload a copy of the applicant's organizational chart.
7. As a QHP issuer, applicant attests that it will notify and obtain HHS approval prior to making any change in ownership that impact the entity(ies) that directly impact the QHP issuer.
8. As a QHP issuer, applicant will:

   (1) Comply with all QHP requirements on an ongoing basis
   (2) Comply with Exchange processes, procedures, and requirements
   (3) Comply with all benefit design standards
   (4) Have a license, be in good standing, and be authorized to offer each specific type of insurance coverage offered in each State in which the issuer offers a QHP
9. Applicant has in place an effective internal claims and appeals process, and agrees to comply with all requirements for an external review process with respect to QHP enrollees, consistent with 45 CFR 147.
10. The applicant (under a current or former name) attests that there are no Federal or State Government past (within 3 years of this submission), current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration against the applicant, its principals, or any of its subcontractors.
11. The applicant (under current of former name) attests that none of its principals, nor any of its affiliates is presently debarred, suspended, proposed for debarment, or declared ineligible to participate in Federal programs under 2 CFR 180.970 or any other applicable statute or regulation.
12. Applicant, Applicant staff, and its affiliated companies, subsidiaries, or subcontractors (first tier, downstream, and related entities), and subcontractor staff agree that they are bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. Please note that this attestation includes any member of the board of directors, key management or executive staff, or major stockholder of the Applicant and its affiliated companies, subsidiaries, or subcontractors (first tier, downstream, and related entities).
13. The applicant agrees that as a QHP issuer it will adhere to all applicable state and federal law.
14. As a QHP issuer, applicant will provide updated rate and benefit information for QHPs offered in the SHOP, if applicable, on a quarterly basis consistent with 45 CFR 156.285(a)(2) and all applicable guidance.

15. As a QHP issuer, applicant will adhere to requirements related to the segregation of funds for abortion services consistent with 45 CFR 156.280 and all applicable guidance.
16. Applicant agrees to use of FFE systems and tools for communication with HHS
17. Applicant agrees to technical requirements related to the use of FFE Plan Management system.
18. As a QHP issuer, applicant agrees to make available the amount of enrollee cost-sharing under an individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of an individual, consistent with 45 CFR 156.220. At a minimum, such information must be made available to such individuals through an Internet website and such other means for individuals without access to the Internet.
19. As a QHP issuer, applicant will set rates for the rates for an entire benefit year and will submit the rate information to the Exchange, including a justification for a rate increase prior to implementation consistent with 45 CFR 156.210.
20. As a QHP issuer, applicant agrees to prominently post rate increase justifications on its website.
21. As a QHP, applicant agrees to adhere to all rating variation requirements pursuant to 45 CFR 156.255.
22. As a QHP issuer, applicant agrees to adhere to provisions addressing payment of federally-qualified health centers in 45 CFR 156.235(e).
23. As a QHP issuer, applicant agrees to offer through the Exchange a minimum of one silver and one gold coverage plans, one child-only plan, and a QHP at the same premium rate in accordance with the requirement of 45 CFR 156.200(c).
24. As a QHP issuer, applicant will not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
25. As a QHP issuer, applicant will provide transparency in coverage in accordance with 45 CFR 156.220.
26. As a QHP issuer, applicant will market its QHPs in accordance with all applicable state laws and regulations and will not employ discriminatory marketing practices in accordance with 45 CFR 156.225.
27. As a QHP issuer, applicant agrees to pay all users fees in accordance with 45 CFR 156.200(b)(6).
28. As a QHP issuer, applicant agrees to adhere with all non-renewal and decertification requirements in accordance with 45 CFR 156.290.
29. As a QHP issuer, applicant attests that the premium rates for its QHPs comply with federal rating requirements or the state's more restrictive rating requirements.
30. As a QHP issuer, applicant attests that its QHPs provide coverage for each of the 10 statutory categories of EHB in accordance with the applicable EHB benchmark plan and federal law.
31. As a QHP issuer, applicant attests that its QHPs provide benefits that are substantially equal to those covered by the EHB-benchmark plan.
32. As a QHP issuer, applicant attests that any benefits substituted in designing QHP plan benefits are actuarially equivalent to those offered by the EHB benchmark plan.
33. As a QHP issuer, applicant attests that its QHPs' benefits reflect an appropriate balance among the EHB categories, so that benefits are not unduly weighted toward any category.

34. As a QHP issuer, applicant attests that its QHPs include all applicable state required benefits.
35. As a QHP issuer, applicant attests that its QHPs comply with preventive services requirements.
36. As a QHP issuer, applicant attests that it will not employ benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs in QHPs in accordance with 45 CFR 156.225.
37. As a QHP issuer, applicant attests that its drug list will be in compliance with federal regulations.
38. As a QHP issuer, applicant agrees to abide by all cost-sharing limits.
39. As a QHP issuer, applicant attests that each QHP complies with benefit design standards in accordance with 156.200(b)(3).
40. As a QHP issuer, applicant attests that its QHPs provide coverage for emergency department services without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan.
41. As a QHP issuer, applicant attests that the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement for in-network and out-of-network providers for emergency department services.
42. As a QHP issuer, applicant attests to follow all Actuarial Value requirements and meet the metal tiers, as appropriate.
43. As a QHP issuer, applicant attests that its catastrophic QHPs will only enroll individuals under the age of 30.
44. Issuer attests that its stand-alone dental plans are limited scope dental plans.
45. Issuer attests that its stand-alone dental plans meet AV requirements.

3.1.2 Quality

1. As a QHP issuer, applicant will comply with the specific quality disclosure, reporting and implementation requirements of 45 CFR §156.200(b)(5) as will be detailed in future guidance.
2. Issuer Accreditation attestation
   a. Issuers with accreditation will attest to the following statements:
      1. The QHP issuer authorizes the release of its accreditation data from the accrediting entity to the FFE (if applicable).

      2. The QHP issuer understands and acknowledges that for issuers with accreditation, prior to 2016, the Exchange Internet website may display data gathered using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, which correspond to the commercial market. If commercial market data is unavailable but data corresponding to Medicaid accreditation is available, the latter may be displayed. This data will be displayed if the following conditions are met:
         - The QHP issuer has authorized the release of its accreditation data as required for QHP certification

- CAHPS® data was considered as part of the QHP issuer's accreditation on Medicaid or commercial lines of business and was submitted to the Exchange by the accrediting entity
- CAHPS® data that was submitted to the Exchange by the accrediting entity is available for the same product type as the QHP that is being offered in the Exchange (e.g., HMO Adult CAHPS® data for HMO QHP, PPO Adult CAHPS® data for PPO QHP, HMO Child CAHPS® data for Child-Only QHP HMO, PPO Child CAHPS® data for Child-Only QHP PPO)

3. The QHP issuer understands and acknowledges that prior to 2016, the Exchange Internet website may display that a QHP issuer is accredited if that issuer is accredited on its commercial, Medicaid, or Exchange product lines by one of the recognized accrediting entities. An accredited status for a QHP issuer will not be displayed if the issuer does not have any products that have achieved at least "provisional" or "interim" status (i.e., an issuer will not be displayed as "accredited" if the accreditation review is scheduled or in process).

b. Issuers who indicate that they are not accredited will attest to the following statements:

1. The QHP issuer understands and acknowledges that for issuers with accreditation, prior to 2016, the Exchange internet website may display data gathered using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, which correspond to the commercial market. If commercial market data is unavailable but data corresponding to Medicaid accreditation is available, the latter may be displayed. This data will be displayed if the following conditions are met:
   - The QHP issuer has authorized the release of its accreditation data as required for QHP certification
   - CAHPS® data was considered as part of the QHP issuer's accreditation on Medicaid or commercial lines of business and was submitted to the Exchange by the accrediting entity
   - CAHPS® data that was submitted to the Exchange by the accrediting entity is available for the same product type as the QHP that is being offered in the Exchange (e.g., HMO Adult CAHPS® data for HMO QHP, PPO Adult CAHPS® data for PPO QHP, HMO Child CAHPS® data for Child-Only QHP HMO, PPO Child CAHPS® data for Child-Only QHP PPO)

3. The QHP issuer understands and acknowledges that prior to 2016, the Exchange Internet website may display that a QHP issuer is accredited if that issuer is accredited on its commercial, Medicaid, or Exchange product lines by one of the recognized accrediting entities. An accredited status for a QHP issuer will not be displayed if the issuer does not have any products that have achieved at least "provisional" or "interim" status (i.e., an issuer will not be displayed as "accredited" if the accreditation review is scheduled or in process).

3.1.3 Enrollment

1. As a QHP issuer, the applicant will meet the individual market requirement to enroll a qualified individual during the initial and annual open enrollment periods; abide by the effective dates of coverage; make available, at a minimum, special enrollment periods; and abide by the effective dates of coverage established by the Exchange.

2. As a QHP issuer, the applicant will maintain termination records in accordance with Exchange standards.
3. As a QHP issuer, the applicant will abide by the termination of coverage effective dates requirements.
4. As a QHP issuer, the applicant will notify the qualified individual of his or her effective date of coverage in coordination with the standards.
5. As a QHP issuer, the applicant will adhere to enrollment information collection and transmission and will:
    - Collect enrollment information using the application adopted
    - Transmit the enrollment information to the Exchange consistent with the standards to facilitate the eligibility determination process
    - Enroll an individual only after receiving confirmation that the eligibility process is complete and the individual has been determined eligible for enrollment in a QHP, in accordance with the standards
6. As an issuer of a QHP, the applicant will accept enrollment information in an electronic format from the Exchange that is consistent with requirements.
7. As an issuer of a QHP, the applicant will provide new enrollees an enrollment information package.
8. As an issuer of a QHP, the applicant will reconcile enrollment files with the Exchange no less than once a month.
9. As an issuer of a QHP, the applicant will acknowledge receipt of enrollment information in accordance with Exchange standards.
10. As a QHP issuer, the applicant will only terminate coverage as permitted by the Exchange.
11. As a QHP issuer, if an enrollee's coverage with a QHP is terminated for any reason, the applicant will provide the Exchange and the enrollee with a notice of termination of coverage that is consistent with the effective date established by the Exchange.
12. As a QHP issuer, the applicant will establish a standard policy for the termination of coverage of enrollees due to non-payment of premium as permitted by the Exchange.
13. As a QHP issuer, the applicant will provide a grace period of at least three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one month's premium.
14. As a QHP issuer, if an enrollee is delinquent on premium payments, the applicant will provide the enrollee with notice of such payment delinquency.
15. As a QHP issuer, if an enrollee receiving advance payments of the premium tax credit exhausts the grace period without submitting any premium payments, the applicant will terminate the enrollee's coverage effective at the end of the payment grace period.
16. As a QHP issuer within an FFE, applicant agrees to develop, operate, and maintain viable systems, processes, and procedures for the timely, accurate, and valid enrollment and termination of enrollees' coverage within the exchange.

17. As a QHP issuer within an FFE, applicant agrees to establish business processes and communication protocols for the prompt resolution of urgent issues affecting enrollees, such as changes in enrollment.
18. As a QHP issuer within an FFE, applicant acknowledges that enrollees can make enrollment changes during open and special enrollment periods for which they are eligible
19. As a QHP issuer within an FFE, applicant will comply with all Exchange requirements regarding involuntary termination of an enrollee initiated by the QHP for the following reasons: 1) Monthly premiums are not paid on a timely basis and is subject to the grace period for late payments, or 2) enrollee provides fraudulent information on his or her application form or permits abuse of his or her benefit cards.
20. As a QHP issuer, applicant agrees to provide required notices to enrollees, including enrollment materials consistent with HHS rules, including but not limited to summary of benefits, evidence of coverage, provider directories, enrollment/disenrollment notices, coverage denials, ID cards, and other standardized mandated notices.
21. As a QHP issuer within an FFE, applicant will give the enrollee written notice(s) of involuntary termination with an explanation of why the QHP is terminating the enrollee. Notices and reason must include an explanation of the enrollee's right to appeal.
22. As a QHP issuer within an FFE, applicant agrees to accurately and thoroughly process and submit the necessary data to validate enrollment and APTC credits on a monthly basis.
23. As a QHP issuer, applicant accepts that the FFE will calculate individuals' premiums and make determinations of individuals' eligibility for the premium tax credit and cost-sharing reduction.
24. As a QHP issuer, applicant approves of the use of the following information for display on the FFE Web site for consumer education purposes:
    - Information on rates and premiums
    - Information on benefits
    - The provider network URL(s) provided in this application
    - The URL(s) for the Summary of Benefits and Coverage provided in this application
    - The URL(s) for payment provided by this application
    - Information on whether the issuer is a Medicaid managed care organization
    - Quality information derived from the accreditation survey, including accreditation status and CAHPS data

3.1.4 Financial Management

1. As a QHP issuer, applicant acknowledges and agrees they are bound by Federal statutes and requirements that govern Federal funds. Federal funds include but are not limited to advance payments of the premium tax credit, cost-sharing reductions, and Federal payments related to the risk adjustment, reinsurance, and risk corridor programs.
2. As a QHP issuer, applicant agrees to make reinsurance contributions at the national contribution rate for the reinsurance program for all reinsurance contribution enrollees who reside in a State, in a frequency and manner determined by HHS as applicable.
3. As a QHP issuer, applicant agrees to make reinsurance contributions to each applicable reinsurance entity for the reinsurance contribution enrollees who reside in the applicable

geographic area, if the State establishes or contracts with more than one applicable reinsurance entity.

4. QHP applicant agrees to submit contributions to HHS on a quarterly basis beginning January 15, 2014.
5. As a QHP issuer, applicant agrees to submit to HHS data required to substantiate the contribution amounts for the contributing entity in the manner and timeframe specified by the State or HHS.
6. As a QHP issuer, applicant acknowledges that only issuers of reinsurance-eligible plans may make a request for payment when an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payment set forth in annual HHS notice of benefit and payment parameters for the applicable year.
7. As a QHP issuer, applicant agrees that they will adhere to the risk adjustment issuer requirements set by HHS in 45 CFR 153.610.
8. As a QHP issuer, applicant agrees to adhere to the risk adjustment compliance standards set by HHS in 45 CFR 153.620.
9. As a QHP issuer, applicant agrees to adhere to the requirements set by HHS in 45 CFR 153.510 and the annual HHS notice of benefit and payment parameters for the establishment and administration of a program risk corridors for calendar years 2014, 2015, and 2016.
10. As a QHP issuer, applicant agrees to remit charges to HHS under the circumstances described in 45 CFR 153.510(c)
11. As a QHP issuer, applicant agrees to adhere to the risk corridor standards set by HHS in 45 CFR 153.520.
12. As a QHP issuer, applicant agrees to adhere to the risk corridor data requirements set by HHS in 45 CFR 153.530
13. As a QHP issuer, applicant agrees to adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit, including the provisions at 45 CFR 156.460, 156.440, and 156.470.
14. As a QHP issuer, applicant agrees to adhere to the standards set forth by HHS for the administration of cost-sharing reductions, including the provisions at 45 CFR 156.410, 156.425, 156.430, 156.440, and 156.470.
15. As a QHP issuer, applicant agrees to submit to HHS the applicable plan variations that adhere to the standards set forth by HHS at 45 CFR 156.420

3.1.5 SHOP

1. I attest that I will adhere to any current or future regulation and guidance with respect to conditioning a QHP issuer's ability to offer QHPs in the individual market Exchange with the offering of QHPs in the SHOP.
2. I attest that I understand QHP premiums in the SHOP may not vary based on the method of plan offering chosen by an employer; OR I attest that I understand QHP premiums in the SHOP may not vary based on method of offering (i.e., employee or employer choice).

3. I attest that I will adhere to any current or future regulation and guidance with respect to agent and broker appointments and commissions in the SHOP.
4. I attest that I will adhere to any current or future regulation and guidance with respect to the holder of a QHP policy, including the understanding that the qualified employer is considered the holder of the QHP policies sold to its employees through the SHOP.

3.1.6 Reporting Requirements

1. As a QHP issuer, the applicant agrees to provide to the Exchange the following "transparency" information in the manner identified by HHS:
    - Claims payment policies and practices
    - Periodic financial disclosures
    - Data on enrollment
    - Data on disenrollment
    - Data on the number of claims that are denied
    - Data on rating practices
    - Information on cost-sharing and payments with respect to any out-of-network coverage
    - Information on enrollee rights under title I of the Affordable Care Act
2. As a QHP issuer, applicant will report required data on prescription drug distribution and costs consistent with 45 CFR 156.295 and all applicable guidance.

3.2 *Delaware Requirements*

See Appendix A: *Delaware Health Benefit Exchange Attestations & Compliance Form for Qualified Health Plans* for attestations to support Delaware-specific laws, regulations and standards.

Attachment 1: Delaware Exchange QHP Attestations & Compliance Form

All QHP Issuers are required to complete and submit the following Attestations sheet indicating compliance with Delaware rules, regulations and state-specific QHP Certification Standards

I, _____, _____ of
(Name) *(Title)*
_____, attest that the plan submission (_____)
(Company / NAIC Co-Code) *(HIOS Plan ID Number)*

is in compliance with all of the laws, regulations, rules, guidance, and standards outlined below.

Check (√) "Y", "N", or "NA" for each of the items below to indicate that the plan complies with each item. If supporting documentation is included, please indicate the appropriate the page number.

Y	N	N/A	Pg #	
				1. Compliance with State Rules & Regulations
				a. Plan complies with Delaware Insurance Law - Chapters 33 and 36, Regulation 1304 - Individual Health Forms
				b. Plan complies with Delaware Insurance Law - Chapter 72, Regulation 1308; Forms & Rates Bulletins Nos. 11-13 - Small Employer
				c. Plan complies with Delaware Insurance Law - Chapter 35, Forms & Rates Bulletin 17 - Group & Blanket Health
				2. Accreditation
				a. Plan complies with federal and state accreditation standards, including provisions in 45 CFR §156.275; 45 CFR §155.1045, and the additional Delaware requirement that all QHP issuers must be accredited on the QHP product type by the third year of operation.
				Note: The state will follow the proposed federal standards for accreditation, including requiring that those QHP Issuers without existing accreditation must schedule the accreditation within the first year of participation in the exchange, and to be accredited on QHP policies and procedures by the end of the second year of certification. **The state will also require in the third year of operation, that all QHP Issuers must be accredited on the QHP product type.** While all Issuers must comply with existing state and federal codes and regulations, Issuers of stand-alone dental plans are exempt from the state's Accreditation standard until such time as accreditation standards, entities and processes are available through federal guidance.
				3. Network Adequacy
				a. Plan complies with requirement that QHP network arrangement must make available to every member a Primary Care Provider (PCP) whose office is located within 20 miles or no more than 30 minutes driving time from the member's place of residence.
				b. Plan complies with requirement that plan network arrangement must meet and require it provides to meet state standards for timely access to care and services as outlined in the

				table, titled Appointment Standards, found on page 27 of 84 in the Delaware Medicaid and Managed Care Quality Strategy 2010 document relating to General, Specialty, Maternity and Behavioral Health Services.
				c. Plan complies with requirement that issuers must establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance and take corrective action if there is a failure to comply with Network Standards including oversight process regarding timely access to care and services.
				d. Plan complies with requirement that each health plan, as a condition of participation in the Exchange, shall (1) offer to each Federally Qualified Health Center (as defined in Section 1905(l)(2)(B) of the Social Security Act (42 USC 1369d(l)(2)(B)) providing services in geographic areas served by the plan, the opportunity to contract with such plan to provide to the plan's enrollees all ambulatory services that are covered by the plan that the center offers to provide and (2) reimburse such centers for such services as provided in Section 1302(g) of the Patient Protection and Affordable Care Act (Publ. L.111-148) as added by Section 10104(b)(2) of such Act.
				4. Rating Areas Attestation
				a. Plan rates do not vary by geographical rating area, as the state of Delaware permits only one rating area.
				5. Service Area Attestation
				a. Plan complies with requirement that the entire geographic area of the State is in the service area of an Exchange, or multiple Exchanges consistent with § 155.140(b). The State of Delaware will require Qualified Health Plan(s) offered by an issuer to be available in all three counties.
				6. DHIN Quality Improvement Standards
				a. Plan issuer will participate in state quality improvement workgroups intended to standardize QHP quality improvement strategies, activities, metrics and operations, including payment structures to improve health outcomes, medical home models and technology and data analytics to improve health outcomes, medical home models and technology and data analytics to support coordination and improved quality and outcomes.
				b. Plan Issuer will be required to participate in and utilize the Delaware Health Information Network (DHIN) data use services and claims data submission services, at prevailing fee structure, to support care coordination and a comprehensive health data set as a component of state quality improvement strategy, unless plan is a stand-alone dental plan. (If plan is a stand-alone dental plan, mark this item as N/A).
				7. Marketing and Benefit Design
				a. Plan marketing and benefit design complies with and will continue to comply with state laws and regulations regarding marketing by health insurance issuers, including Delaware Insurance Code Title 18§23 Unfair Methods of Competition and Unfair or Deceptive Acts and the requirements defined in 18 Del Admin Code § 1302 Accident and Sickness Insurance Advertisements.
				8. Dental Compliance with Title 18, Chapter 38 (if applicable)
				a. Plan complies with Delaware Title 18, Chapter 38 (Dental Plan Organization Act) if plan is offering dental coverage, including embedded dental or stand-alone dental coverage. (If plan does not offer dental coverage, mark this item as N/A.)
				9. Actuarial Value
				a. Plan issuer has separately offered or plans to offer in the same plan year at least one QHP at the Bronze level, as well as the Silver and Gold as required by the federal standard 45 CFR

				§156.225.
				10. Marketing Regulations and Transparency
				a. Plan complies with state and federal marketing and transparency regulations, including the Unfair or Deceptive Acts and Unfair Methods of Competition Act (Delaware Insurance Code Title 18§23; 18 Del Admin Code§ 1302) as well as federal regulations including, but not limited to, 45 CFR **§**156.220 which requires the publication of cost-sharing data on Issuer Internet web site.
				11. Market Reform Rules
				a. Plan complies with all Federal Market Reform rules including, but not limited to PHS 2701; PHS 2702; PHS 2703; PPACA §1302(e); PPACA §1312(c); PPACA §1402; 43 CFR §156; 42 CFR §147. (Note: There are no Delaware-specific market reform rules).
				12. Compliance with Essential Health Benefits
				a. Plan Dental benefits offered that are substantially equal to benefits offered in the Delaware dental benchmark plan (CHIP). Note: If plan does not include dental benefits, mark this item as N/A.
				b. Plan includes medical benefits are substantially equal to the benefits offered in the Delaware benchmark plan (BCBS EPO)
				c. Plan includes vision benefits that are substantially equal to the benefits offered in the Delaware vision benchmark plan (FEDVIP)
				13. Continuity of Care
				a. Plan issuer has a transition plan for continuity of care for those individuals who become eligible or lose eligibility for public health programs. The Continuity of Care Transition Plan includes a transition period for prescriptions, including how the plan specifically addresses mental health pharmacy. Plan issuer is responsible for executing the Transition plan.
				b. Plan issuer agrees to comply with withdrawal and transition plan requirements as stated in Del.c. 18 subsection §3608 for Individual plans.
				c. Plan issuer agrees to comply with withdrawal and transition plan requirements as stated in Del.c. 18 subsection §7207 for Small Group plans.
				d. Plan issuer has submitted a withdrawal and transition plan to the Department of Insurance for review/approval.
				e. For treatment of a medical condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, plan issuer agrees to cover the service for a lesser of: a period of 90 days or until the treating provider releases the patient from care.
				f. Plan issuer agrees to provide a continuity/transition period of at least 60 days for medications prescribed by a provider and agrees to cover the prescribed medication at a tier comparable to the plan from which the individual was transitioned.
				g. Plan issuer agrees to provide a continuity/transition period of at least 90 for a mental health diagnosis and agrees to cover medications prescribed by the treating provider for the treatment of the specific mental health diagnosis for at least 90 days. Issuer agrees that the prescribed medication must be covered at a tier comparable to the plan from which the individual transitioned.
				14. Transparency
				a. Plan issuer agrees to ensure that cost-sharing data is published on Internet Web Site, clearly and in plain language.

				15. Broker/Producer Compensation
				a. Plan issuer agrees to ensure that commissions paid to brokers/producers for QHPS sold through the Individual Exchange and FF-SHOP are the same as those paid in the outside market.

_____ _____

Printed Name/Title *Signature/Date*